

ATTACHMENT 9

Sample Prior Authorization Request Form (PA/RF) for durable medical equipment

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE ? ICN	AT	Prior Authorization Number 1234567
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SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I. M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number ? Billing Provider (XXX) XXX-XXXX	3. Processing Type 130
4. Billing Provider's Medicaid Provider Number 12345678		

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 436 Acute, but ill-defined cerebrovascular disease				11. Start Date — SOI		12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description 342.9 Hemiplegia, unspecified				14. Requested Start Date 12/01/03					
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4				18. POS	19. Description of Service	20. QR	21. Charge
	K0004					12	High strength, lightweight wheelchair Invacare Patriot	1	XXXX.XX
	E0192					12	Jay active cushion	1	XXX.XX
	K0108					12	Headrest with hardware	1	XXX.XX
	K0108					12	Custom drop seat	1	XX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.								22. Total Charges	X,XXX.XX

23. SIGNATURE — Requesting Provider I.M. Provider	24. Date Signed MM/DD/YY
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FOR MEDICAID USE	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved Grant Date _____ Expiration Date _____		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
SIGNATURE — Consultant / Analyst		Date Signed